AHI
PCMH 2014 Elements Explained

Standard/Element	Explanation
PCMH 1: Patient-Centered Access	
PCMH 1A: Patient Centered Appointment Access **(MUST PASS)**	The practice has a written policy for making appointments available for both urgent and routine issues. The policy states time requirements and defines "routine" and "urgent". For example, the practice has a policy that urgent issues are seen immediately and routine visits (eg, new patient physicals, return visit exams to monitor mile acute and chronic conditions) are scheduled within seven days. The practice triages patients to determine the urgency of a request for a same-day appointment; triage considers patient care need and preference.
PCMH 1B: 24/7 Access to Clinical Advice	Patients may access the clinician and care team, for routine and urgent needs by office visit, by telephone and by secure electronic messaging when the office is closed. Clinical advice provided via telephone and secure electronic messaging is documented in patient records, for continuity of care.
PCMH 1C: Electronic Access	The practice offers information to patients and their families via a secure electronic system. Patients can view their medical record, access services and communicate with the health care team electronically.
PCMH 2: Team-Based Care	
PCMH 2A: Continuity	Patients and their families may select a personal clinician who works with a defined health care team. The selection is documented in the patient's record. Practice staff are aware of a patient's personal clinician or team and work to accommodate visits and communication. A team is a primary clinician and associates clinical (including behavioral health care providers) and support staff who work with the clinician. A personal clinician may represent a mid-level clinician or medical resident under a supervising physician, who share a panel of patients.
PCMH 2B: Medical Home Responsibilities	The practice has a documented process for giving patients/families/caregivers information about the role and responsibilities of the medical home, including a) specific services patients can expect from the practice; b) whom to contact for specific concerns, questions and information; and c) the roles of the care team.
PCMH 2C: Culturally and Linguistically Appropriate Services	The practice uses data to assess the diversity and needs of its population so it can meet those needs adequately. The practice is encouraged to provide information in multiple formats to accommodate patient preference and language needs.

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PCMH 2D: The Practice Team **(MUST PASS)**	Managing patient care is a team effort that involves clinical and nonclinical staff (ie, physicians, nurse practitioners, physician assistants, nurses, medical assistance, educators, schedulers) interacting with patients and working as a team to achieve stated objectives. The clinician leading the team is integral to determining and enacting the processes established by the practice. The emphasis is on ongoing interactions of team members to discuss roles, responsibilities, communication and patient hand-off, working together to provide and enhance the care provided to patients. Involvement of the patient/family/caregiver with care team members is critically important to patient-centeredness.
PCMH 3: Population Health Management	
PCMH 3A: Patient Information	The practice uses a practice management, E.H.R. or other electronic system that collects and records patient information in searchable data fields.
PCMH 3B: Clinical Data	The practice collects patient clinical information through an E.H.R. or other electronic system. The system can be searched for each factor and can create reports.
PCMH 3C: Comprehensive Health Assessment	In addition to a physical assessment, a standardized, comprehensive patient assessment includes an examination of social and behavioral influences. The practice determines how frequently it updates the health assessment, using evidence-based guidelines. Patients with an active diagnosis or aspect of care indicating a need are reassessed at each relevant visit. The practice should consider how its comprehensive health assessment helps establish criteria and supports a systematic process for identifying patients for care management.
PCMH 3D: Use Data for Population Management **(MUST PASS)**	The practice uses registries and proactive reminders to address a variety of health care needs. The practice creates list or reports of: patients who need preventive care; patients who need immunization and chronic care services; patients who have not been seen recently; patients who take specific medications. The practice may use mail, telephone or email, directly or through external vendors to remind patients when services are due.
PCMH 3E: Implement Evidence-Based Decision Support	The practice maintains continuous relationships with patients through care management processed based on evidence-based guidelines. A key to successful implementation of guidelines is to embed them in the practice's day-to-day operations (frequently referred to as "clinical decision support"). Clinical Decision Support (CDS) is a systematic way to prompt clinicians to consider evidence based guidelines at the point of care. CMS notes that CDS is "not simply an alert, notification, or explicit care suggestion. CDS encompasses a variety of tools including, but not limited to: computerized alerts and reminders for providers and patients, clinical guidelines, condition-specific order sets, focused patient data reports and summaries, documentation templates, diagnostic support, contextually relevant reference information."
PCMH 4: Care Management and Support	

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	PCMH 4A: Identify Patients for Care Management	The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of behavioral health conditions, high costs/high utilization, poorly controlled or complex conditions, social determinants of health and referrals. The intent is that practices use defined criteria to identify true vulnerability - a single criterion, such as cost, may not be an appropriate indicator of need for care management.
	PCMH 4B: Care Planning and Self-Care Support **(MUST PASS)**	The care team and patient/family/caregiver collaborate on developing and updating an individualized care plan that addresses whole-person care. The care plan specifies the services offered by and responsibilities of the primary care practice and, if appropriate, integrates with a care plan created for the patient by a non-primary care providers to avoid potential overlap or gap in services and care. A ***care plan*** considers and/or specifies various areas related to a patient's care, which could include: patient preferences and functional/lifestyle goals; treatment goals; assessment of potential barriers to meeting goals; strategies for addressing potential barriers to meeting goals; care team members, including the primary care provider of record and team members; current problems; current medications; medication allergies; a self-care plan.
	PCMH 4C: Medication Management	The practice reviews and documents in the medical record all prescribed medications the patient is taking. Medication review and reconciliation occurs, at least annually, at transitions of care and at relevant visits. Maintaining a list of current medications and resolving medication conflicts reduces the possibility of duplicate medications, medication errors and adverse drug events. A process for reconciling medications is essential for patient safety.
	PCMH 4D: Use Electronic Prescribing	The practice uses an electronic prescribing system that ensures prescriptions written by the practice are compared with drug formularies to identify covered drugs and the copayment tier; and are sent to pharmacies electronically. Utilizing an electronic prescribing system will ensure the most cost effective therapies are prescribed, and reduces the possibility of medication errors and adverse drug events.
	PCMH 4E: Support Self Care and Shared Decision Making	The practice offers patients tools and support to better enable self-care. This includes classes, educational aids and other resources. Programs may be offered through community agencies, a health plan or a patient's employer. Even if the practice provides one or more services, it also identifies services or agencies available in the community that are relevant to the practice's population.
PCMH 5: Care Coordination and Care Transitions		
	PCMH 5A: Test Tracking and Follow Up	The practice systematically tracks tests to ensure that needed tests are performed and results are acted on, when necessary. Ineffective management of laboratory and imaging test results can result in less than optimal care and may compromise patient safety. The practice tracks lab and imaging tests from the time they are ordered until results are available, and flags test results that have not been made available. The practice follows up with the lab or diagnostic center (and the patient, if necessary) to determine why results are overdue.

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	PCMH 5B: Referral Tracking and Follow Up **(MUST PASS)**	Referrals are tracked by the practice using a log or electronic system, as determined by the clinician to be important to a patient's treatment or as indicated by practice guidelines (eg, referral to a surgeon for examination of a potentially malignant tumor; referral to a mental health specialist for a patient with depression; referral to a pediatric cardiologist for an infant with a ventricular septal defect). The practice tracks referrals from the time they are made until a report is received back from the specialist and flags cases where a report has not yet been received. The practice follows up with the specialist (and the patient, if necessary) to determine why a report is overdue.
	PCMH 5C: Coordinate Care Transitions	Effective transitions of care - between primary care and specialist providers, between facilities, between physicians and institutional settings - ensure that patient needs and preferences for health services and sharing information across people, functions and sites are met over time. Enhancing care transitions across providers can improve coordination of care and its effect on quality and efficiency.
PCMH 6: Performance Measurement and Quality Improvement		
	PCMH 6A: Measure Clinical Quality Performance	At least annually, the practice reviews its performance on a range of measures to help it understand its care delivery system's strengths and opportunities for improvement, including immunization measures, preventive care measures, chronic or acute care measures - and performance data is stratified for vulnerable populations. When possible, the practice uses measures from existing sources and other reporting activities it is involved in (eg, PQRS, Meaningful Use, UDS, HEDIS).
	PCMH 6B: Measure Resource Use and Care Coordination	At least annually, the practice reviews its performance on a range of measures to help it understand its care delivery system's strengths and opportunities for improvement, including care coordination and utilization measures affecting health care costs. The practice is able to report quantitative data for these measures, and can assess "better" or "worse" results over time. A ***care coordination*** measure assesses "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services."
	PCMH 6C: Measure Patient/Family Experience	At least annually, the practice obtains feedback from patients/families on their experience with the practice and their care, evaluating access, communication, coordination and/or whole-person/self-management support. The practice uses survey feedback to inform its quality improvement activities.
	PCMH 6D: Implement Continuous Quality Improvement **(MUST PASS)**	The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Review and evaluation offer an opportunity to identify and prioritize areas of improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers. The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA) that represents a commitment to ongoing quality improvement and goes beyond setting goals and taking action.

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	PCMH 6E: Demonstrate Continuous Quality Improvement	Quality improvement is a continual process that is guilt into the practice's daily operations and requires an ongoing effort of assessing, improving and reassessing. This element emphasizes ongoing quality improvement through comparison of performance results to demonstrate that the practice has gone beyond setting goals and taking action.
	PCMH 6F: Report Performance	The practice shares performance results on quality improvement activities with clinicians and practice staff, patient and the public.
	PCMH 6G: Use Certified E.H.R. Technology	The practice protects the privacy and security of its patients' health information, through the use of a certified E.H.R. system, and contributes to electronic population health management registries as appropriate.

Updated by RuthAnn Craven, 01.08.2016